Sean F. Melton, D.D.S., F.A.G.D., P.C.
301 Saddle Drive
Helena, MT 59601
406-443-1419

Welcome! We would like to get to know you better.

PATIENT INFORMATION

Name____ If Child, Parents Name ___________________________
Address _______________________________________ City _______________ ST______ Zip _____________
Social Security # _______________________________________ Date of Birth ____________________________
Phone # __________________ Cell # ___________________ Email Address ____________________________
Employer ____ Work # __________________________
Spouses Name ____________________________ Do you have any children? ____________________________
Emergency Contact ____________________________ Relationship ______________ Phone # _____________
How did you hear about our office? _______________________ When was your last dental visit? _____________
Reason for leaving your last dentist? ____
If you could change one thing about your smile/teeth, what would it be?____________________________________
Reason for your visit today? ____
Do you have an **extreme fear** of the dentist or dental treatment? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Subscriber _______________________________ Subscriber's ID # _________________________
Subscriber's Date of Birth ___________________________ Relationship to Patient _________________________
Name of Carrier _____________________________ Phone # ___________________ Group # _____________
Is Patient covered by additional insurance? ☐Yes ☐ No **If 'Yes', please fill out the following information…**
Secondary/**Medical** ____________________________ Phone # ________________ Group # ________________
Name of Subscriber _______________________________ Subscriber's ID # ____________________
Subscriber's Date of Birth ___________________________ Relationship to Patient _________________________
I authorize payment of my insurance benefit directly to my dentist. _________________________________Patient Signature

HEALTH & DENTAL HISTORY

No	YES	ACID REFLUX/HEARTBURN*	No	YES	HIV	No	YES	BLEEDING GUMS
No	YES	ARTHRITIS	No	YES	KIDNEY DISEASE	No	YES	SENSITIVITY TO COLD
No	YES	ARTIFICIAL JOINTS	No	YES	LIVER DISEASE	No	YES	SENSITIVITY TO HOT
No	YES	ASTHMA	No	YES	MENTAL DISORDERS	No	YES	SENSITIVITY TO SWEETS
No	YES	BLOOD DISEASE	No	YES	NERVOUS DISORDERS	No	YES	PAIN WHEN BITING
No	YES	CANCER	No	YES	PACEMAKER	No	YES	JAW PAIN/TENDERNESS
No	YES	DIABETES I or II*	No	YES	RESPIRATORY PROBLEM	No	YES	CLICKING/POPPING OF THE JAW
No	YES	DIZZINESS	No	YES	RHEUMATIC FEVER	No	YES	JAW JOINT PAIN
No	YES	EPILEPSY	No	YES	RHEUMATISM	No	YES	DO YOU GRIND YOUR TEETH?*
No	YES	PROLONGED BLEEDING	No	YES	SEIZURES	No	YES	DO YOU SNORE?*
No	YES	FAINTING	No	YES	SINUS PROBLEMS	No	YES	DO YOU HAVE SLEEP APNEA?
No	YES	GLAUCOMA	No	YES	STOMACH PROBLEMS	No	YES	DO YOU USE TOBACCO?
No	YES	HAY FEVER	No	YES	STROKE*	No	YES	**I am or may be pregnant.**
No	YES	HEART AILMENT*	No	YES	TOURRETS			
No	YES	HEART MURMUR	No	YES	TUBERCULOSIS			HAVE YOU HAD TEETH REMOVED? No YES
No	YES	HEPATITIS A, B, or C	No	YES	TUMORS			If "yes" date of removal __________________
No	YES	HIGH BLOOD PRESSURE*	No	YES	VENEREAL DISEASE			

No ☐ YES **ALLERGY TO LATEX /SPECIFIC DRUGS. List all drug allergies**______________________________
Have you had surgery? ☐ YES ☐ NO If yes please specify____
List any additional health conditions: ____
List all medications you are taking: ____
I have been given the opportunity to read the Notice of Privacy Policy for Melton Dental and give consent for use and disclosure of my health information if necessary. **INITIALS** __________

NAME OF YOUR PRIMARY CARE PHYSICIAN________________________________

CONSENT

I give consent for x-rays and any dental treatment for myself or child if patient is a minor.

Signed _____________________________Date ________

Update ________________________Date __________ Update _____________________Date ____________